907 KAR 1:604. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54, 447.59, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1, 1397aa -1397jj, 2014 Ky. Acts ch. 117, Part I.G.3.b.(10)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.82, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments for Medicaid recipients. This administrative regulation establishes the provisions relating to Medicaid Program copayments.

Section 1. Definitions. (1) "Community spouse" means the individual who is married to an institutionalized spouse and who:

(a) Remains at home in the community; and

(b) Is not:

1. Living in a medical institution;

2. Living in a nursing facility; or

3. Participating in a 1915(c) home and community based services waiver program.

(2) "Copayment" means a dollar amount representing the portion of the cost of a Medicaid benefit that a recipient is required to pay.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Dependent child" means a couple’s child, including a child gained through adoption, who:

(a) Lives with the community spouse; and

(b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(5) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.

(6) "Drug" means a covered drug provided in accordance with 907 KAR 23:010 for which the Department for Medicaid Services provides reimbursement.

(7) "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

(8) "Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

(9) "KCHIP" means the Kentucky Children's Health Insurance Program.

(10) "KCHIP - Separate Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(11) "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(12) "Medicaid Works individual" means an individual who:

(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B) would be considered to be receiving supplemental security income;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;
2. Tax returns;
3. 1099 forms; or
4. Proof of quarterly estimated tax;

(d) Meets the income standards established in 907 KAR 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

(13) "Nonemergency" means a condition which does not require an emergency service pursuant to 42 C.F.R. 447.53.

(14) "Nonpreferred brand name drug" means a brand name drug that is not on the department's preferred drug list.

(15) "Preferred brand name drug" means a brand name drug:

(a) For which no generic equivalent exists which has a more favorable cost to the department; and

(b) Which prescribers are encouraged to prescribe, if medically appropriate.

(16) "Preventive service" means:

(a)1. All of the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); or

2. All approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices;

(b) Preventive care and screening for infants, children, and adults recommended by the Health Resources and Services Administration Bright Futures Program Project; or

(c) Preventive services for women recommended by the Institute of Medicine.

(17) "Recipient" is defined in KRS 205.8451(9).

(18) "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits in accordance with 907 KAR 20:005, Section 5(5).

Section 2. Copayments. (1) The following table shall establish the:

(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost sharing pursuant to Section 3(1) of this administrative regulation; and

(b) Corresponding provider reimbursement deductions.

Benefit	Copayment Amount
Acute inpatient hospital admission	$50
Outpatient hospital or ambulatory surgical center visit	$4
Generic prescription drug	$1
Preferred brand name drug	$4
Nonpreferred brand name drug	$8
Emergency room for a nonemergency visit	$8
DMEPOS	$4
Podiatry office visit	$3
Chiropractic office visit	$3

Dental office visit	$3
Optometry office visit	$3
General ophthalmological office visit	$3
Physician office visit	$3
Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife	$3
Office visit for behavioral health care	$3
Office visit to a rural health clinic	$3
Office visit to a federally qualified health center or a federally qualified health center look-alike	$3
Office visit to a primary care center	$3
Physical therapy office visit	$3
Occupational therapy office visit	$3
Speech-language pathology services office visit	$3
Laboratory, diagnostic, or radiological service	$3

(2) The full amount of the copayment established in the table in subsection (1) of this section shall be deducted from the provider reimbursement.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 3. Copayment General Provisions and Exemptions. (1)(a) Except for a foster care child, a recipient shall not be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.

(b) A copayment shall not be imposed for a service, prescription, item, supply, equipment, or any type of Medicaid benefit provided to a foster care child.

(c) Except for the mandatory copayment referenced in paragraph (a) of this subsection, the department shall impose no cost sharing for the following:

1. A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19), and who is required to be provided medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available

under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;

2. A preventive service;

3. A service furnished to a pregnant woman;

4. A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);

5. A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;

6. An emergency service as defined by 42 C.F.R. 447.53;

7. A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or

8. A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).

(2) The department has determined that any individual liable for a copayment shall:

(a) Be able to pay a required copayment; and

(b) Be responsible for a required copayment.

(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.

(4) A parent or guardian shall be responsible for a copayment imposed on a dependent child under the age of twenty-one (21).

(5) Any amount of uncollected copayment by a provider from a recipient shall be considered a debt to the provider.

(6)(a) A provider shall:

1. Collect from a recipient the copayment as imposed by the department for a recipient in accordance with this administrative regulation;

2. Not waive a copayment obligation as imposed by the department for a recipient; and

3. Collect a copayment at the time a benefit is provided or at a later date.

(b) Regarding a service or item for an enrollee in which the managed care organization in which the enrollee is enrolled does not impose a copayment, the provider shall not collect a copayment from the enrollee.

(7) Cumulative cost sharing for copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.

(8) In accordance with 42 C.F.R. 447.82, the department shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient.

Section 4. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual shall pay a monthly premium that is:

1. Based on income used to determine eligibility for the program; and

2. Established in subsection (2) of this section.

(b) The monthly premium shall be:

1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no more than 150 percent of the FPL;

2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no more than 200 percent of the FPL; and

3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more than 250 percent of the FPL.

(2) An individual whose family income is equal to or below 100 percent of the FPL shall not

be required to pay a monthly premium.

(3) A Medicaid Works individual shall begin paying a premium with the first full month of benefits after the month of application.

(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual shall not be required to pay the missed premium before reenrolling.

Section 5. Provisions for Enrollees. A managed care organization:

(1) Shall not impose a copayment on an enrollee that exceeds a copayment established in this administrative regulation; and

(2) May impose on an enrollee:

(a) A lower copayment than established in this administrative regulation; or

(b) No copayment.

Section 6. Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7. Appeal Rights. An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

Section 8. Effective Date. The cost sharing provisions and requirements established in this administrative regulation shall be effective beginning January 1, 2014.

Section 9. Federal Approval and Federal Financial Participation. The department's copayment provisions established in this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation; and

(2) Centers for Medicare and Medicaid Services' approval.

Section 10. This administrative regulation was found deficient by the Administrative Regulation Review Subcommittee on May 13, 2014. (29 Ky.R. 1458; Am. 2201; 2478; eff. 4-11-2003; 30 Ky.R. 1117; 1533; eff. 2-16-2004; 32 Ky.R. 417; 925; 1111; eff. 1-6-2006; 33 Ky.R. 607; 1386; 1568; eff. 1-5-2007; 34 Ky.R. 1840; 2117; eff. 4-4-2008; TAm eff. 7-16-2013; Tam eff. 8-7-2013; TAm eff. 9-30-2013; 40 Ky.R. 1991; 2524; 2749; eff. 7-7-2014; TAm eff. 10-6-2017.)